COUNTY OF ORANGE, CA **HEALTH CARE AGENCY**

REVOCATION OF AUTHORIZATION

TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

PHOTOCOPY/FACSIMILE COPY MAY USED AS AN ORIGINAL

CLIENT(PATIENT) INFORMATION:

NAME: _____
Last *First* *MI*

AKA: _____

SOC. SEC.#: _____ DATE OF BIRTH: _____

I hereby REVOKE the authorization to use or disclose the named individual's Protected Health Information as described here.

Individual or organization originally authorized to use or disclose PHI:

☐ County of Orange, CA – Health Care Agency

☐ Other- Specify:_____ Complete Address:_____
(Individual, Organization, Facility) Street Address City State Zip Code

Individual or organization originally authorized to receive the information:

☐ Other – Specify: _____ Complete Address:_____
(Individual, Organization, Facility) Street Address City State Zip Code

☐ County of Orange, CA – Health Care Agency

MEDICAL RECORDS/PHI (California Civil Code 56.10, TITLE 17, Health and Safety Code 120175)) AND OTHER INFORMATION

Initials	Treatment Date(s):	Facility Location(s)	Type of Record(s)/Information to be Released
			☐ Any and All ☐ Specific Record(s)/Info: (Please Indicate Below) _____

PSYCHIATRIC/MENTAL HEALTH/INCLUDING PSYCHOTHERAPY NOTES PHI (CAL W&I Code Section 5328)

Initials	Treatment Date(s):	Facility Location(s)	Type of Record(s)/Information to be Released
			☐ Any and All ☐ Specific Record(s)/Info: (Please Indicate Below) _____

ALCOHOL/SUBSTANCE ABUSE TREATMENT PHI (Section 42 Part 2 Code of Federal Regulations)

Initials	Treatment Date(s):	Facility Location(s)	Type of Record(s)/Information to be Released
			☐ Urine Test Results ☐ Progress in Treatment ☐ Dates of Attendance ☐ Other: _____

HIV RESULTS/AIDS TREATMENT PHI (Health and Safety Code 120980)

Initials	Treatment Date(s):	Facility Location(s)	Type of Record(s)/Information to be Released
			☐ Any and All ☐ Specific Record(s)/Info: (Please Indicate Below) _____

Limits of Revocation: I understand that this revocation will not apply to information that has already been released based on the authorization I signed on: _____

TODAY'S DATE: _____ **SIGNATURE:** _____

PRINTED NAME: _____

RELATIONSHIP: *Choose One*: ☐ Client(Patient) ☐ Parent ☐ Guardian ☐ Representative ☐ Conservator ☐ Other: _____

COMPLETE ADDRESS _____ **TELEPHONE #** ( ) -
Street Address City State Zip Code

Please return this completed form for processing to the Custodian of Records office at 511 N. Sycamore, Santa Ana, Ca 92701
Phone (714) 834-3536;Fax (714) 835-9312